

VA 1. 55/2: 989/1



Department of
Veterans Affairs

Digest

Inspector General Report to Congress

For the 6-month period
October 1, 1988 to March 31, 1989

This digest contains highlights of the twenty-first Semianual Report to Congress by the Inspector General. The digest is intended to promote greater awareness and understanding of challenges the Department faces and to elicit support for the positive efforts management is taking in response to Office of Inspector General reports to improve VA operations and delivery of services to veterans.

Audits and investigations conducted during this period focused on strengthening program controls; identifying opportunities for program cost efficiencies and dollar recoveries; improving the efficiency of VA facility operations; identifying loan guaranty, third party, and entitlement frauds; and identifying instances of employee misconduct.

Management's positive response to audit recommendations provides the opportunity for significant efficiencies and improvements in current programs and operations, and the convictions and administrative sanctions resulting from investigations should help to deter future program abuses.

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Office of Inspector General

The Department of Veterans Affairs (VA) Office of the Inspector General (OIG) was created by Congress in 1978 to provide independent and objective reviews of VA programs and operations. A comprehensive program of audits and investigations is conducted to assist management in promoting economy and efficiency and in preventing and detecting fraud and abuse in the administration of VA programs and operations.

During this semiannual period, the OIG had funding of approximately \$10 million and maintained an average employment of 381.

Operational Results

The potential cost recoveries and efficiencies for the 141 audit reports and 334 investigations totaled \$508 million. An estimated \$44 million in potential recoveries has been identified for Department management to pursue collection. Also, investigative efforts led to criminal and administrative sanctions against VA employees, benefits recipients, and third parties who violated the law. The 104 criminal convictions and 74 administrative sanctions resulting from investigations penalized those who circumvented the laws and should help deter future abuses.

Following is a description of audit and investigative findings by major subject area:

delivery of medical care

- A nationwide audit and seven facility audits found significant overexerting of outpatient visits and specialized ambulatory services. Internal controls in these areas were not satisfactory. Improved controls leading to more accurate reporting of outpatient workload could result in a better annual allocation of an estimated \$102 million in medical care funds.
- Audits of quality assurance systems at 13 VA medical centers found that the centers needed to strengthen their controls over areas such as criteria for continuous monitors, medical records documentation, patient incident reporting, medication profile development and analyses, and hospital length-of-stay analyses. Recommended improvements would result in better data for evaluations of patient care.

other medical program issues

- An audit of VHS&RA implementation of the Resources Allocation Methodology (RAM) model

showed that some medical center managers were not always following RAM reporting procedures and thus gained fund allocation advantages. Greater oversight and guidance are needed, and improved RAM reporting could result in a better allocation of an estimated \$74 million in medical care funds.

- Audits of security service activities at five VA medical centers disclosed significant deficiencies in the oversight and management of security activities. Crimes were not being adequately investigated or reported, violation notices were not enforced, and the FBI was usually not informed of property losses at the medical centers. Improvements are needed to better protect patients, employees, and property.

recipient eligibility

- The final OIG state wage match for beneficiary fraud has identified over \$11 million in overpayments and about \$1 million in future annual payment avoidance. Referrals of overpayments for investigation and possible criminal prosecution have been made in 309 cases. There were 51 indictments and 49 convictions during this period on pension cases resulting from the state wage matching program. This matching program, originated by the OIG, is now being operated by the Veterans Benefits Administration (VBA).
- Some veterans, who underwent successful kidney transplant surgery, did not have their disability ratings reduced resulting in excessive payments of about \$10 million. Also, reducing the period of convalescence during which total disability payments are paid could reduce payments an additional \$3 million annually.
- Improved controls were needed to safeguard the assets of 66,000 beneficiaries who receive \$659 million annually in benefit payments and have assets valued around \$3 billion. Independent verification of reported assets and certification of assets on deposit are needed to protect these assets from theft or misuse by fiduciaries.

loan guaranty

- A program audit of loan servicing showed improved timeliness of lender default reporting and loan servicing could result in more effective assistance to veterans and reduce VA loan guaranty losses by \$85 million in FY 1989.
- An audit of one regional office determined that inaccurate and incomplete estimates of the value of

foreclosed property increased loan guaranty losses by almost \$42 million.

- An ongoing joint investigation with the Federal Bureau of Investigation (FBI) and the Department of Housing and Urban Development (HUD) has resulted in an additional 21 convictions and \$112,000 in fines, penalties, and restitution during this period. These investigations involve equity skimming, loan origination fraud, and other loan guaranty schemes.

procurement and construction

- The VA supply fund was overcapitalized because of an OMB policy precluding use of inventory as a budget resource for the fund. As a result of the audit, the VA is seeking a partial exemption that would apply to approximately \$60 million in medical center warehouse inventory.
- Medical center assessments of construction needs could be reduced by about \$31 million based on OIG recommendations to cancel or scale down projects at several medical centers.
- As a result of a joint OIG investigation with the Department of Health and Human Services (HHS), the Food and Drug Administration (FDA), and Department of Justice (DOJ), a \$5 million settlement was reached with a firm who sold defective pacemakers to the Government.

employee integrity

- We continue to place a high investigative priority on ethics and employee integrity. There were 27 administrative actions taken, as a result of IG investigations, against employees for conflicts of interest, theft of Government property, false claims, embezzlement, and drug theft.

Contract Audits

The OIG contract audit staff monitors the Department contract audit process and reviews and performs audits of VA contractors and grantees. Completed reports contained total audited costs of \$345 million representing \$274 million in estimated purchases under FSS contracts and \$71 million in contract and grant costs incurred, price proposals, and claims. Questioned and unsupported costs totaled \$19.5 million. One audit report was referred for investigation of possible irregularities.

Prevention and Other Significant Activities

In addition to its operational audit and investigative role, the OIG is responsible for a wide range of preventative and other activities that contribute to fulfilling the OIG's overall mission objectives.

complaint center

Recognizing that individuals both inside and outside the Government can be valuable sources of information in promoting efficiency, economy, and effectiveness of operations, the OIG Complaint Center operates a telephone hotline service 24 hours a day, 7 days a week. During this period 219 cases were opened and 208 cases closed. Thirty-nine of the closed cases contained founded allegations and resulted in 55 administrative sanctions and cost recoveries and efficiencies totaling \$63,000.

security

The OIG has responsibility for administering the Department's personnel and information security programs. The personnel security program serves as one of the Department's primary defenses against fraud. Using background investigations and National Agency Checks and Inquiries, the integrity and past conduct of VA employees is thoroughly reviewed. The information security program helps assure that the Department's classified and other sensitive documents are adequately safeguarded and protected. Activities during the period included granting 327 individuals eligibility and access to sensitive positions, and referring 331 arrest records for a suitability review.

technical laboratory

The OIG operates a technical laboratory for the examination of official documents, handwriting, typewriting, inks, paper, and various other questioned materials. During this reporting period, 62 OIG requests were received for laboratory examinations of 1,970 documents. Successful laboratory examinations included a determination that veterans' signatures had been forged and as a result, VA was able to start collection action for \$85,000 against five mortgage companies. In another case, laboratory examiners determined that a former VA attorney had forged veterans' signatures and embezzled \$127,000.

quality assurance

Public Law 100-322 (June 1988) required the Secretary to upgrade and expand the activities of the OIG in overseeing, monitoring, and evaluating VHS&RA quality assurance programs and activities of the Medical Inspec-

tor. The OIG is required to provide the Chief Medical Director, the Secretary, and the Congress with clear and objective assessments of the effectiveness of these programs and activities. The OIG continues to make significant progress in following through on its Public Law 100-322 implementation plan submitted to the Administrator and Congress in July 1988. Special actions taken during this period were:

- Recruited a physician to head the Quality Assurance Review Division and serve as a medical advisor to the IG.
- Staffed the Quality Assurance Review Division with a compliment of experienced medical care health system specialists.
- Formally established and staffed a quality assurance "desk officer" position within the Office of the Assistant Inspector General for Auditing that will serve as the focal point for quality assurance audit activities on both program and cyclic audits.
- Developed and issued a draft comprehensive quality assurance audit guide for use by OIG audit staff in cyclic audits of VA medical centers.
- Held, in coordination with VHS&RA officials, a quality assurance seminar for selected OIG field and headquarters personnel.
- Transferred Medical Inspector oversight responsibility from another division within the OIG to the new Quality Assurance Review Division.

other

The Inspector General reviews existing and proposed legislation and regulations relating to Department programs and operations for their impact on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse. During this period, 39 legislative and 80 regulatory proposals were reviewed and comments provided. Also, during this reporting period, we processed 68 requests under the Freedom of Information and Privacy Acts and released 261 audit, investigative, and other OIG reports.

summary of operations**6 Months
10/1/88 to
3/31/89****(Dollars in
Millions)****AUDIT ACTIVITIES**

• Total Audit Reports Issued	141
• Internal Audit Reports Issued	60
• External Audit Reports Issued	81
• Value of Audit Reports Issued	
Potential Recoveries	\$ 37
Potential Cost Efficiencies	\$ <u>464</u>
TOTAL	\$ 501
• Audit Reports Resolved (issued this and prior periods)	100
• Costs Sustained on Resolved Audits (issued this and prior periods)	
Recovery Commitments	\$ 24
Estimated Cost Efficiencies	\$ <u>371</u>
TOTAL	\$ 395
• Audit Reports Unresolved (3/31/89)	34
• Value of Unresolved Reports	
Potential Recoveries	\$ 44
Potential Cost Efficiencies	\$ 299

INVESTIGATION ACTIVITIES

• Investigation Cases Opened	446
• Investigation Cases Closed	334
• Investigation Cases Pending	1075
• Investigation Cases Referred for Prosecution	361
• Prosecution Accepted	37
• Indictments	113
• Convictions	104
• Civil Judgments	4
• Prison Sentences (in years)	20
• Fines, Penalties, and Settlements	\$ 6
• Administrative Recoveries	\$.5
• Cost Efficiencies	\$.1
• Administrative Sanctions	74

COMPLAINT CENTER ACTIVITIES

• Cases Opened	219
• Cases Closed	208
• Administrative Sanctions	55
• Cost Recoveries/Efficiencies	\$.1

OTHER ACTIVITIES

- Proposed Legislation and Regulations Reviewed 119

INSPECTOR GENERAL RESOURCES

- Average Employment 381
- Budget \$ 10



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